# MEMORANDUM
## OFFICE OF THE COUNTY MANAGER

ED&HS
AGENDA ITEM NO. 4(L)

TO: Honorable Chairperson Barbara Carey-Shuler, Ed.D. and Members, Board of County Commissioners

DATE: February 11, 2004

FROM: George M. Burgess, County Manager

SUBJECT: **Resolution Directing the County Manager to Develop and Implement the Miami-Dade County Health Flex Plan**

**RECOMMENDATION**

It is recommended that the Board of County Commissioners direct the County Manager to develop and implement the Miami-Dade County Health Flex Plan (Plan) to provide health care coverage for up to a total of 5,000 working uninsured residents including their families.

Upon Board direction, staff would:

- pursue financial arrangements to obtain federal matching funds
- work with the Department of Procurement Management to expeditiously retain the services of a professional Medicaid healthcare management consultant to assist in critical aspects of the initial set-up:
  - promptly proceed with developing the program design,
  - assist in the development and incorporation of the 501(c)(3) corporation, in consultation with the County Attorney's Office, and
  - secure state and federal financing arrangements
- continue to work on developing the program design, including service delivery options and eligibility requirements
  - developing an expansive definition of "family" consistent with Section 39.01 (28), Florida Statutes
  - allowing children who are on the waiting list for KidCare to be considered for the Plan consistent with State practices
  - identifying the minimum number of hours for an employee to qualify for the Plan
- appoint a fiscal agent during the 501(c)(3) corporation development phase.

**BACKGROUND**

At the September 17, 2003 Miami-Dade Board of County Commissioners Budget Hearing, the County Commission allocated $1.3 million for the development and implementation of the Health Flex Plan. The County Commission further directed staff to report on the status of the Health Flex Plan. This Report was provided at the January 20, 2004 Board of County Commissioners Meeting. As a result, Commissioners directed staff to prepare a resolution incorporating Commissioners' comments resulting from the Manager's Report on the proposed Miami-Dade County Health Flex Plan. That report is attached as additional background information.

Barbara Jordan
Assistant County Manager

# MEMORANDUM

(Revised)

**TO:** Hon. Chairperson Barbara Carey-Shuler, Ed.D. and Members, Board of County Commissioners

**DATE:** March 16, 2004

**FROM:** Robert A. Ginsburg
County Attorney

**SUBJECT:** Agenda Item No.

**Please note any items checked.**

_____ **"4-Day Rule" ("3-Day Rule" for committees) applicable if raised**

_____ **6 weeks required between first reading and public hearing**

_____ **4 weeks notification to municipal officials required prior to public hearing**

_____ **Decreases revenues or increases expenditures without balancing budget**

_____ **Budget required**

_____ **Statement of fiscal impact required**

_____ **Bid waiver requiring County Manager's written recommendation**

_____ **Ordinance creating a new board requires detailed County Manager's report for public hearing**

_____ **Housekeeping item (no policy decision required)**

_____ **No committee review**

Approved _____ Mayor Agenda Item No.
Veto _____
Override _____

RESOLUTION NO. _____

RESOLUTION DIRECTING THE COUNTY MANAGER THROUGH THE OFFICE OF COUNTYWIDE HEALTHCARE PLANNING TO DEVELOP AND IMPLEMENT THE MIAMI-DADE COUNTY HEALTH FLEX PLAN TO PROVIDE HEALTH CARE COVERAGE FOR UP TO A TOTAL OF 5,000 WORKING UNINSURED RESIDENTS INCLUDING THEIR FAMILIES

**WHEREAS,** more than half a million residents in Miami-Dade County do not have access to quality, convenient or affordable healthcare coverage; and

**WHEREAS,** it is estimated that approximately 200,000 of these residents are working, uninsured individuals with incomes up to 200% of the Federal Poverty Level (FPL); and

**WHEREAS,** the Mayor's Health Care Access Task Force recommended the creation of a public/private partnership program to offer affordable health insurance to employed, low-income uninsured individuals; and

**WHEREAS,** this Board has encumbered $1.3 million for fiscal year 2003-2004 as local funding for the development and implementation of the Miami-Dade County Health Flex Plan; and

**WHEREAS,** this Board desires to accomplish the purposes outlined in the accompanying memorandum and report, a copy of which are incorporated herein by reference;

**NOW, THEREFORE, BE IT RESOLVED BY THE BOARD OF COUNTY COMMISSIONERS OF MIAMI-DADE COUNTY, FLORIDA,** that this Board directs the County Manager through the Office of Countywide Healthcare Planning to (a) develop and implement the Miami-Dade County Health Flex Plan to provide health care coverage for up to a total 5,000 working uninsured residents of Miami-Dade County including their families; and (b) pursue financial arrangements for federal matching funds; and (c) work with the Department of

Procurement Management to expeditiously retain the services of a professional Medicaid healthcare management consultant to assist in critical aspects of the initial set-up; and with the County Attorney's Office to assist in the development and incorporation of the 501(c)(3) corporation.

The foregoing resolution was offered by Commissioner , who moved its adoption. The motion was seconded by Commissioner and upon being put to a vote, the vote was as follows:

Dr. Barbara Carey-Shuler, Chairperson
Katy Sorenson, Vice-Chairperson

| | |
|---|---|
| Bruno A. Barreiro | Jose "Pepe" Diaz |
| Betty T. Ferguson | Sally A. Heyman |
| Joe A. Martinez | Jimmy L. Morales |
| Dennis C. Moss | Dorrin D. Rolle |
| Natacha Seijas | Rebeca Sosa |
| Sen. Javier D. Souto | |

The Chairperson thereupon declared the resolution duly passed and adopted this 16th day of March, 2004. This resolution shall become effective ten (10) days after the date of its adoption unless vetoed by the Mayor, and if vetoed, shall become effective only upon an override by this Board.

MIAMI-DADE COUNTY, FLORIDA
BY ITS BOARD OF COUNTY
COMMISSIONERS

HARVEY RUVIN, CLERK

Approved by County Attorney as
to form and legal sufficiency. ES

By:_____
Deputy Clerk

# MEMORANDUM
## OFFICE OF THE COUNTY MANAGER

Agenda Item No. 11(B)10

TO: Honorable Chairperson Barbara Carey-Shuler, Ed.D. and Members, Board of County Commissioners

DATE: January 20, 2004

FROM: George M. Burgess, County Manager

SUBJECT: **Health Flex Plan Report**

**OVERVIEW**

At the September 17, 2003 Miami-Dade Board of County Commissioners Budget Hearing, the County Commission allocated $1.3 million for the development and implementation of the Health Flex Plan. The County Commission further directed staff to report on the status of the Health Flex Plan. This Report provides a brief background and overview of the Health Flex Plan as originally recommended by the Mayor's Healthcare Access Task Force. The concept of a flex plan is described, along with the proposed eligibility criteria and benefits. Attachment A compares the proposed benefits and co-pays with other Flex Plans. The Report characterizes the scope of the uninsured crisis in Miami-Dade County. The County's fiscal impact is addressed and the proposed innovative funding mechanism to draw down federal matching funds is explained. The Report also highlights recent activities undertaken by the Office of Countywide Healthcare Planning and describes specific tasks necessary for implementation to occur. Attachment B, the Miami-Dade County Health Flex Plan Development 2004 Time Line, provides a sequential progression of the major task areas. Attachment C, the Miami-Dade County Health Flex Plan Concept Paper, represents an in-depth summary and analysis of the Health Flex Plan. Attachments D and E contain resolutions of support from the Greater Miami Chamber of Commerce and from the South Florida Hospital and Healthcare Association, respectively. Attachment F reflects a proposed bill to allow the development of flex plan pilot programs statewide.

**BACKGROUND**

The Florida Agency for Health Care Administration (AHCA) and the Florida Department of Financial Services review and approve applicants for the Health Flex Plan Pilot Program created by Senate Bill 46-E in the 2002 legislative session and amended by Senate Bill 22-A in the 2003 legislative session. The 2003 session's amendment extended the expiration date to July 1, 2008 and allowed for " . . . the enrollee who purchases coverage directly from the plan or through a small business purchasing arrangement sponsored by a local government . . . "

The Flex Plan proposal represents one of the final recommendations issued by the Mayor's Healthcare Access Task Force (Task Force).[1] The Task Force was launched in Spring 2002 to address the growing uninsured crisis in Miami-Dade County. Several committees were created to

[1] This report draws from the Mayor's Healthcare Access Task Force – Final Report 2003 and from the Expanding Coverage for the Working Uninsured Committee's Final Report, December 2002.

address specific areas of concern. One committee, the Expanding Coverage for the Working Uninsured Committee (Committee), was charged with identifying solutions for the working uninsured population. The Committee examined alternatives to expand healthcare insurance to employers. The proposed Flex Plan serves as the Committee's final product.

## I. FLEX PLAN OVERVIEW

A. Key Assumptions

The Flex Plan concept represents a national trend, mirrored in the State of Florida, to provide affordable health care insurance to the uninsured. The Flex Plan is an alternative to traditional health insurance, is less regulated and emphasizes basic and preventive health care. The coverage is anticipated to be less expensive because of the focus on preventive care and provision of limited high-end benefits, than health insurance programs and HMO coverage that are currently available.

The key assumptions of the Flex Plan include:

- emphasis on providing primary and preventive care to improve community health and reduce the inappropriate use of the emergency room
- reduced plan benefits to make health insurance more affordable
- public/private partnership to maximize public resource allocations

B. Anticipated Eligibility and Enrollment

- Eligible participants will be employed, uninsured Miami-Dade County residents 64 years of age or younger and their families, with household incomes up to 200% of the Federal Poverty Limit (FPL), not eligible for any public insurance program (including Medicare, Medicaid or KidCare), and without health coverage for the past twelve months (state minimum is a less restrictive six month period of noncoverage). This latter criteria controls for "crowd-out" of existing coverage by employers for their employees by placing a one-year non-coverage (waiting period) requirement. The state does not require participants to be employed.
- Small business employers in Miami-Dade County who have between 2-50 employees will be eligible to participate in the program if they have not offered insurance to their employees during the preceding twelve months. Additionally, they must agree to pay one-third of the monthly premium for each employee covered.
- Although models have previously been prepared to serve 20,000 or 50,000 individuals, staff is now recommending the development and implementation of a pilot Flex Plan program to enroll up to 5,000 working uninsured and their families. Any enrollment increases would then be approved by the County Commission.

C. Flex Plan Services

- While the Flex Plan concept supports a reduced benefit package to increase affordability, the proposed Miami-Dade County Health Flex Plan benefits are more expansive. A sample benefit package was developed to provide services comparable to those provided in the Medicaid program. The sample benefit package includes: physician services (primary and specialty care office visits, pre/postnatal care, urgent care), hospital services (inpatient, outpatient, and emergency room), generic prescription drugs, contraceptives, ancillary services (durable medical

equipment and supplies), diagnostics (mammography, MRI, lab, x-ray, etc.), and ambulance services.

- Attachment A provides a direct benefit comparison of existing and proposed Flex Plan programs in the state. The benefits offered by American Care, Preferred Medical Plan, and JaxCare are not as extensive as are those proposed for the Miami-Dade County Health Flex Plan. Correspondingly, the monthly premiums are lower in these reduced benefit plans, ranging between $35 and $100, as compared to the County's proposed total monthly premium of $120. It is important to note that these other plans do not cover hospital inpatient services and two of the three do not cover emergency services.
- Upon County Commission approval, a professional Medicaid/healthcare management consultant in collaboration with the Office of Countywide Healthcare Planning (OCHP) will develop the exact benefit offerings based on employer focus group research and meetings with healthcare professionals. The final benefit package will be presented to the County Commission for its approval. The Flex Plan is designed, however, to promote benefits that are somewhat limited and to encourage participants to seek primary care, to avoid the use of emergency rooms and limit inpatient hospital services.

## II. MIAMI-DADE COUNTY'S UNINSURED/UNDERINSURED

A. Number and Healthcare Usage of Uninsured

The most recent survey on health insurance, conducted last year by the University of Florida for the Public Health Trust entitled the Miami-Dade County Health Insurance Survey shows that 26.7 percent, slightly more than one in every four residents of Miami-Dade residents under the age of 65, are uninsured. An estimated 543,403 Miami-Dade County residents under age 65 are uninsured. The number of uninsured residents in Miami-Dade County is increasing. This reflects an increase of approximately 2 percent over the last four years (based on the previous 1999 Florida Health Insurance Survey commissioned by AHCA). Based on projected population increases and assuming the uninsured rate remains the same, the number of uninsured will increase by more than 50,000 to total 594,742 uninsured by 2010.

Contrary to common belief, a full 60 percent of the uninsured are working. As employers face higher insurance premiums and either pass on costs to employees or eliminate health insurance benefits altogether, greater numbers of workers will be negatively impacted. Small employers are less likely to have insured workers. As a tourist economy, Miami-Dade has many small employers who do not offer health insurance to their employees. Nearly 30 percent of the full-time employees of Miami-Dade County businesses with fewer than ten employees are uninsured, compared with 5.9 percent in businesses of 100 or more employees.

Compared to the insured, the uninsured are less likely to seek care, including prenatal and preventive care, as well as treatment for chronic conditions. Less than two-thirds (63%) of Floridians without insurance have a usual source/provider of health care compared with 89 percent of those with insurance. Furthermore, 14 percent of the uninsured report the emergency room as their usual source of care, contrasted with only 3 percent of the insured. Finally, the uninsured are more likely to have delayed or not obtained needed medical care in the previous year (39% compared with 9%).

## III. FLEX PLAN – FISCAL IMPACT

A. Premium Costs

Participants will pay a monthly premium with co-payments for some services (see Attachment A). The proposed benefits are estimated to cost $107 per member per month (PMPM) with an additional $13 PMPM for administration costs, for a total cost of $120 PMPM split three ways for a $40 cost to the employee, $40 cost to the employer, and $40 cost to the program (using County and Federal government funding).

An extensive outreach program would likely cost an additional $5 to $10 per member per month. The exact costs for this program will need to be determined by an actuary following completion of the final program design. The proposed program design requires participants to utilize physicians, hospitals and other providers who are part of the program network. Use of out-of-network providers (if included in the design) would require increased co-payments. The addition of dental, mental health and substance abuse benefits can be included for an added cost.

B. Governmental Share of Premium

The County has allocated $1.3 million during the current fiscal year for the Flex Plan. The County's contribution will be matched with money from the federal government to cover the one-third government portion. The County's contribution of 41% of every dollar would yield 59% of every dollar from the Federal government. The total program cost, including administrative costs to operate the program, is included in the $1.3 million start-up funding.

Federal funds will be leveraged for this program to the maximum extent possible via the utilization of Upper Payment Limit (UPL) financing arrangements to pull down federal funds to match local funds allocated to the program. Medicaid participating hospitals have the ability to access additional state and federal funds (i.e., funds in excess of the customary Medicaid payment) using the UPL methodology. The UPL is the maximum rate that can be paid under the Medicaid program. Florida has approximately $100 million available in the private hospital UPL program, a portion of which could be allocated to hospitals in Miami-Dade County. The public hospital UPL program, for example, the Public Health Trust, cannot pull down additional federal funds because it has reached its maximum allowable limit.

C. Federal Funding

Medicaid participating hospitals have the ability to access additional state and federal funds (i.e. funds in excess of the customary Medicaid payment) using the UPL methodology. The UPL rate reflects the amount the federal Medicare program would have paid for that same hospital charge. The difference between the Medicare payment and the Medicaid payment is made available to states through the UPL mechanism. In order for a state to claim federal financial participation (FFP), the state match must be the result of an intergovernmental transfer (IGT), a broad based provider tax or a specific state appropriation.

The UPL for publicly owned hospitals has been fully utilized by the State of Florida. Jackson Health System is a major beneficiary, with the local public funding provided by the Public Health Trust. The PHT "contributes" local tax funding to the Medicaid program through an intergovernmental transfer, and the hospitals receive additional Medicaid funding in return.

The UPL available for private hospitals has not been fully utilized by the State of Florida, however because only government entities may transfer funds to the State. Because the UPL payments are made back to hospitals, there has been limited interest from local governmental units in contributing their tax funds to the Medicaid program to benefit private hospitals.

The process to draw down the federal UPL funds would require the County to allocate its contribution to the state (via AHCA) to be used as the match for the federal private hospital UPL funds. AHCA would disperse the combined government funds to the participating private hospitals that would then disburse a like amount of non-UPL funds to a County-approved 501(c)(3) for distribution to the health plan organization operating the Flex Plan. It is crucial that the County allocates its portion in order to draw down the federal funds.

The following process must occur to access the UPL funds. The State's Disproportionate Share Hospital (DSH) Task Force must recommend and approve the plan. The recommendation would be made directly to the State Legislature for the upcoming legislative session. The Legislature must then approve the specific dollar amount in the appropriations language (even though the state is not making a financial contribution). This will allow AHCA to have the budget authority to allocate the funds conditional upon federal Centers for Medicare and Medicaid Services (CMS) approval and availability of local matching funds. Upon legislative approval, the funds may be effective July 1, 2004 and available retroactively after CMS approval. AHCA would need to gain the approval of the UPL program from CMS via an amendment to its state plan. This approval process may take between three to six months. With County Commission direction, it would be prudent to pursue the UPL distribution category request as soon as possible for this legislative session. Please note that recommendations from the Governor's Task Force on Access to Affordable Health Insurance include the development of flex plans and that state legislation has been developed to allow pilot programs statewide (Attachment F).

It is important to note that AHCA cannot issue any requirement to the participating private hospitals on what to do with the funds beyond that of general provisions in the proviso language as consistent with CMS regulations. However, both the County and the 501(c)(3) can each have formal agreements with the participating hospitals to allocate a like amount of non-UPL funds to the 501(c)(3). In addition, the entire (public and private hospitals) UPL program requires an annual approval from CMS. However, there is no indication that this federally matched program will experience funding shortfalls in the foreseeable future.

## IV. EMPLOYER INTEREST

The Office of Countywide Healthcare Planning has been working with the Health Council of South Florida to identify the community's interest in participating in the Health Flex Plan, including the implementation of an employer survey, employer and consumer focus group (roundtable) research, chambers of commerce meetings, and discussions with experts.

Preliminary findings from two small business (employer) roundtables conducted by the Health Council of South Florida indicate that participating employers are willing to share in the cost of their employee's monthly premium, if they perceive the health plan as having value. Participants expressed their desire for primary care, hospital services, prescription drugs, and diagnostic services. They were also favorable to a one-third sharing of the premiums to include a government

contribution. The results of additional activities will be presented to you as soon as they are available.

## V. FLEX PLAN – IMPLEMENTATION TASKS

As mentioned above in section III C, Federal Funding, several financing tasks need to be addressed, including identifying private hospitals to participate in the UPL program and obtaining state and federal approval for utilizing private hospital UPL funds. Additionally, the County and the 501(c)(3) would execute separate written agreements with the participating hospitals delineating their respective roles (consistent with federal regulations).

The hiring of a professional Medicaid/healthcare management consultant, through the Department of Procurement Management (DPM), is necessary to expeditiously advance the design and development work of this project. It is imperative to obtain the services of a consultant that has the breadth of experience designing similar health plans, assisting in the development of a 501(c)(3), and securing relevant state and federal financing arrangements.

An independent non-profit corporation must be formed in order to receive funds from the participating hospitals while remaining in compliance with federal regulations regarding provider donations. The 501(c)(3) will be responsible for governing and overseeing the Health Flex Plan. Upon County Commission direction, staff (County Attorney's Office) would identify the appropriate structure for establishing the 501(c)(3) consistent with federal regulations controlling the flow of UPL dollars. The consultant would provide technical assistance to the County with establishing a 501(c)(3) non-profit corporation.

The 501(c)(3) would recruit and hire a Flex Plan director and outreach director to work with the consultant in the plan development, including benefit design, finalizing eligibility requirements, developing detailed service delivery options, and developing other program design features and options for County Commission approval. A detailed actuarial study for soundness of the Flex Plan benefits, rates and expenses would be performed in accordance with state requirements, as well as readiness reviews verifying credentialing, network capacity, and start-up capability would be required. Additionally, AHCA requires that coordination be developed with existing community services and that a marketing plan be submitted. The 501(c)(3), working with the consultant, would develop and issue a provider RFP, and would finalize and execute a contract. The awarded bidder(s) would then apply to be a Health Flex applicant with AHCA and would prepare for service delivery. The applicant would assume the risk of ensuring health care coverage, not the County.

The 501(c)(3) would need to hire temporary (conditional upon the size of the enrollment cap) employer navigators and employee navigators to conduct outreach and enrollment activities. The employer navigator would visit interested employer sites to orient the employer on the Flex Plan and its requirements. The employee navigators would screen participants to determine if they qualify for any publicly funded program (such as Medicaid or KidCare/Healthy Kids).

In preparation for outreaching to the community, especially to employers about the Flex Plan, the AHCA requirement of developing a Marketing Plan with strategies for reaching the population must be fulfilled. A contract, also via the 501(c)(3), must also be launched with the employee navigators

to outreach and enroll employees to the Health Flex Plan after it is determined they do not qualify for other health care programs. This will involve a media campaign, activation of Team Metro and employer and employee navigators to commence the program. A mass media promotion will be launched involving the Mayor and Commissioners and utilizing the Answer Center to receive incoming phone calls.

Attachment B, Miami-Dade County Health Flex Plan Development 2004 Time Line, provides an overview of the major tasks to be accomplished by monthly periods. If there are no delays, the Miami-Dade County Health Flex Plan can begin enrollment as early as December 2004.

## CONCLUSION

Justification for County Investment

One argument in favor of the County participating in the Flex Plan is that it provides a "bigger bang for the buck" by leveraging federal dollars. This allows County dollars to go farther in providing health care. For example, the TrustCare program, which is the Public Health Trust's pilot health benefit program in south Miami-Dade, is 100% funded by the County via the Trust. Patients do not pay any premiums or co-pays, nor do employers pay, nor are there any federal matching funds. In contrast, under the Flex Plan, the County's portion would be 41% of the government's share of 33% (employer and employee each pay 33%). On a projected monthly premium of $120 per member, the County's share would be $16.40, not the full $120 nor the one-third amount of $40 that the employer and employee would pay. In essence, the County's contribution becomes 13.53% instead of 33%. This maximizes the funding and allows more residents to participate.

Additionally, the County should invest the funding initially in the Health Flex Plan because of the long-term savings that can be reached through this innovative plan. In-depth preventive health care studies have shown that not only is the cost in emergency and indigent care rapidly rising, but the number of uninsured is reaching a vast epidemic. Investing in preventive health care will yield cost savings in future years. As the local government policy-maker, the Miami-Dade County Board of County Commissioners is facing the need to provide more indigent health care locally, especially as the number of uninsured continues to rise.

It is inherent in the County's mission to build a healthier community. A healthier person results in a more productive and attentive worker and in return, this rewards governmental efforts with added value to the local community's productivity, profitability and efficiency.

Assistant County Manager

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Attachment A

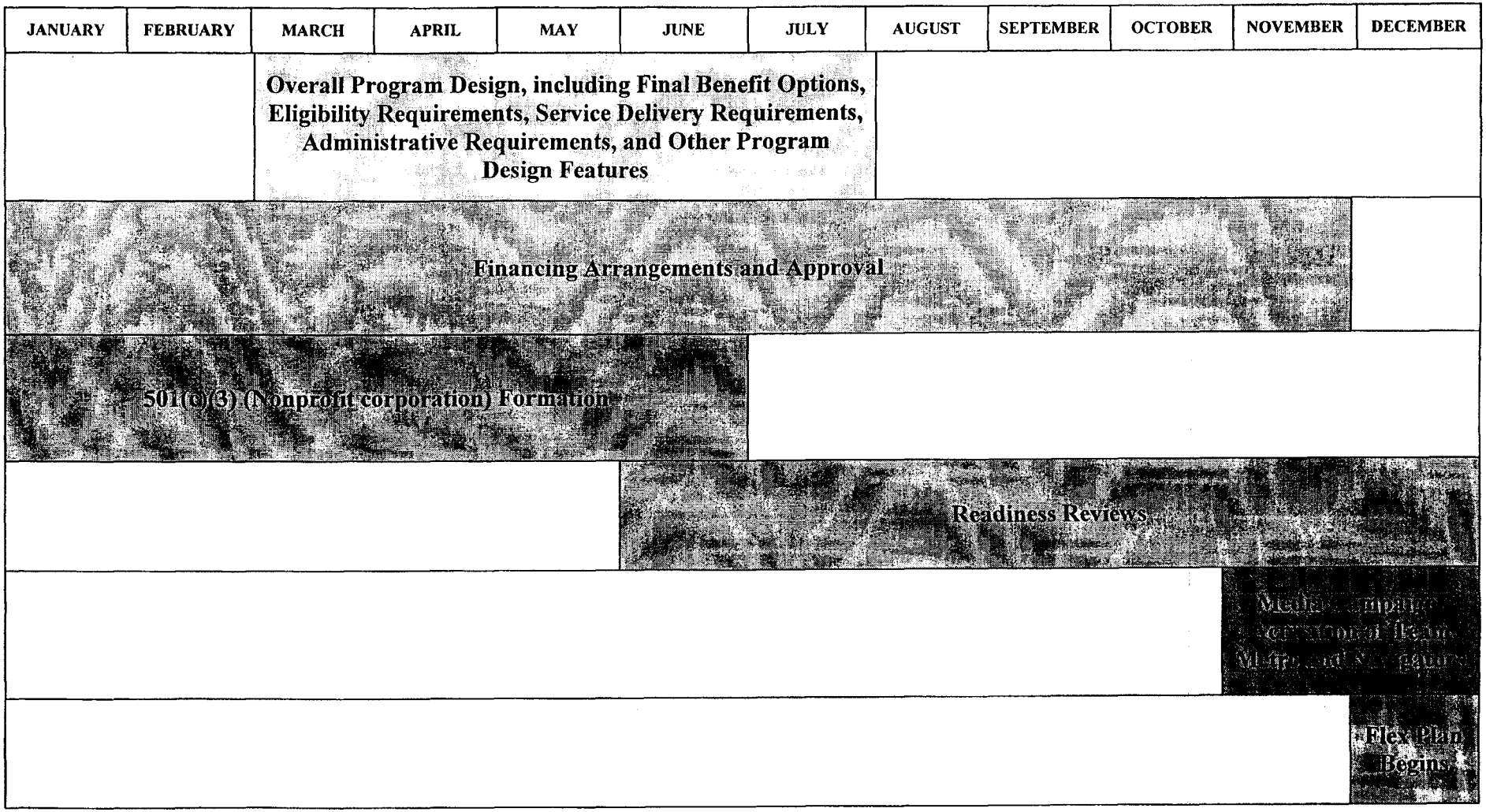
# BENEFITS AND CO-PAY COMPARISON WITH OTHER FLEX PLANS

| BENEFITS | MIAMI-DADE COUNTY HEALTH FLEX PLAN (proposed pilot) | AMERICAN CARE | PREFERRED MEDICAL PLAN | JAXCARE (JACKSONVILLE) | JMH HEALTH PLAN FLEX PLAN (proposed pilot) |
|---|---|---|---|---|---|
| PRIMARY CARE | $5 | $7 | $10 | $10 | $5 |
| SPECIALISTS | $10 | $40 | Not Covered | $10 | $15 |
| EMERGENCY SERVICES | $10/25/50 per day* | Covered only at its Medical Center | Not Covered | Not Covered | $100 |
| INPATIENT | $25/50/100 per day* 20 day annual cap | Not Covered | Not Covered | Not Covered – only in-kind contribution | $100 |
| OUTPATIENT (Surgery) | $10/25/50 per day* $1,000 annual cap | $200 | Not Covered | Not Covered | $50 |
| URGENT CARE | $10 | $50 | Not Covered | $25 | $15 |
| AMBULANCE | $10 | Not Covered | Not Covered | $100 | Not Covered |
| HOME HEALTH SERVICES | Not Covered | Not Covered | Not Covered | $10 (60 visit max | Not Covered |
| REHAB THERAPY | Not Covered | $30 (dr. office only) | Not Covered | combined) | Not Covered |
| DURABLE MEDICAL EQUIP | $10 | Not Covered | Not Covered | $50 ($1000 max) | Not Covered |
| MENTAL HEALTH | Not Covered | $40 | Not Covered | $10 (20 visit max | Not Covered |
| SUBSTANCE ABUSE | Not Covered | Not Covered | Not Covered | combined) | Not Covered |
| LABORATORY SERVICES | $5 | $10 | No Charge | Physician Office Only | No co-pay |
| DIAGNOSTIC SERVICES | $5 | $35 Aggregate | $42.50 Aggregate | Not Covered | $20-$100 |
| MAMMOGRAM | $5 | $50 | $30 | Not Covered | $20 |
| PHARMACY | $5; 4 generics monthly | Not Covered | $10 generics | Generic Only | $5 generics |
| DENTAL | Not Covered | Not Covered | Rider | Not Covered | Not Covered |
| VISION | eye exam covered within primary care | Not Covered | Rider | Not Covered | Not Covered |
| ANNUAL CAP | None | None | $70,000 | None | $15,000 |
| PREMIUM | $40 Employee<br>$40 Employer<br>$40 Government (proposed) | $35-$49<br>Up to 200% FPL | $40<br>Up to 200% FPL | $50 Employee<br>$50 Employer<br>150-200% FPL | <100% FPL None<br>100-150% $52.61<br>151-200% $78.52 (proposed) |

**NOTE:** * A sliding co-pay scale has been proposed for these services based on income (under 100%, 100-150%, 150-200% of the federal poverty level).

Attachment B

# Miami-Dade County
# Health Flex Plan Development
# 2004 Time Line



Attachment C

# Miami-Dade County

# HEALTH FLEX PLAN
# Concept Paper

Prepared by:
M-D County Health Policy Authority
Hilary J. Hoo-you, M.S.W., M.B.A.
Marty Lucia, Ph.D.

September 8, 2003

# Health Flex Plan Concept Paper

**September 8, 2003**

## Overview/Background

Overview

This paper discusses the proposed Health Flex Plan (Flex Plan) for consideration by the Board of County Commissioners. It presents the Plan's features and benefits; enrollment and targeted population; it discusses Miami-Dade's uninsured population; identifies the problem and presents alternative resolutions; it critically analyzes the Plan; it compares similar models in other areas; it examines the fiscal impact and potential funding scenarios; and addresses long range issues.

Background

The Florida Agency for Health Care Administration (AHCA) and the Florida Department of Insurance review and approve applicants for the Health Flex Plan Pilot Program created by Senate Bill 46-E in the 2002 legislative session and amended by Senate Bill 22-A in the 2003 legislative session. The last session's amendment extended the expiration date to July 1, 2008 and allowed for ". . . the enrollee who purchases coverage directly from the plan or through a small business purchasing arrangement sponsored by a local government . . . "

The Health Flex Plan proposal represents one of the final recommendations issued by the Mayor's Healthcare Access Task Force (Task Force).[1] The Task Force was launched in Spring 2002 to address the growing uninsured crisis in Miami-Dade County. Several committees were created to address specific areas of concern. One committee, the Expanding Coverage for the Working Uninsured Committee (Committee), was charged with identifying solutions for the working uninsured population. The Committee examined alternatives to expand healthcare insurance to employers.

## I. Flex Plan Overview

A. Key Assumptions

The Health Flex Plan is a national trend, mirrored in the State of Florida, to provide affordable health care insurance to the uninsured. The Flex Plan is an alternative to traditional health insurance and emphasizes basic and preventive health care. The coverage is anticipated to be less expensive, via the provision of fewer benefits, than health insurance programs or HMO coverage that are currently available. The key assumptions of the Flex Plan include:

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[1] This paper draws from the Mayor's Healthcare Access Task Force – Final Report 2003 and from the Expanding Coverage for the Working Uninsured Committee's Final Report, December 2002.



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- reduced plan benefits in order to make health insurance more affordable

- emphasis on providing primary and preventive care to improve community health and reduce the inappropriate use of the emergency room

- public/private partnership is desirable to maximize public resource allocations

B. Anticipated Enrollment

- Eligible participants will be employed, uninsured Miami-Dade County individuals and their families, with incomes under 200% of the Federal Poverty Limit (FPL), and not eligible for any public insurance programs (including Medicare, Medicaid or KidCare/Healthy Kids)

- Models have been prepared to serve 20,000 or 50,000 individuals and will be dependent on the County Commission as to the amount of people and the financial commitment that it is desirous of serving. Both financial models are described on page 11.

C. Flex Plan Services

- The exact benefit offerings will be determined and approved by the County Commission. Flex Plan is designed, however, to promote benefits which are limited and to encourage participants to seek primary care, to avoid the use of emergency rooms and limit inpatient hospital services.

- The proposed services include: physician services (primary and specialty care office visits, pre/postnatal care, urgent care), hospital services (inpatient, outpatient, and emergency room), generic prescription drugs, contraceptives, ancillary services (durable medical equipment and supplies), diagnostics (mammography, lab, x-ray, etc.), and ambulance services.

- There are controls for "crowd-out" of existing coverage by employers for their employees by placing a one year non-coverage (waiting period) requirement.

- A sample benefit plan is displayed in the sample benefit summary table presented on the next page.

| | | | | |
|---|---|---|---|---|
| *Physician Services* | | | | |
| • Primary Care Office Visit | $5/visit | | | limited to network |
| • Specialty Care Office Visit | $10/visit | | | limited to network |
| • Pre/Postnatal Care | $0 | | | limited to network |
| • Urgent Care | $10 | | | limited to network |
| *Hospital Services*[2] | | | | |
| • Inpatient | $25/day | $50/day | $100/day | 20 days/yr |
| • Outpatient | $10/day | $25/day | $50/day | $1,000 cap/yr |
| • Emergency Room | $10/day | $25/day | $50/day | |
| *Prescription Drugs* | $5 | | | Generics only/4 Rx per month maximum |
| *Contraceptives* | $5 | | | 12 Rx per year |
| *Ancillary Services* | | | | |
| • Durable Medical Equipment/Supplies | $10/item | | | limited to network |
| • Diagnostics (lab, x-ray, etc.) | $5/procedure | | | limited to network |
| • Ambulance | $10/trip | | | waived if admitted |

## II. Miami-Dade County's uninsured/underinsured

A. Number of Uninsured

The number of uninsured residents in Miami-Dade County is increasing. The most recent survey on health insurance, conducted earlier this year by the University of Florida for the Public Health Trust entitled the Miami-Dade County Health Insurance Survey shows that 26.7 percent, slightly more than one in every four residents of Miami-Dade residents under the age of 65, are uninsured. This reflects an increase of approximately 2 percent over the last four years (based on the previous 1999 Florida Health Insurance Survey commissioned by AHCA). Table 1 on the next page shows that an estimated 543,403 Miami-Dade County residents under age 65 are uninsured in 2003. Based on projected population increases and assuming the uninsured rate remains the same, the number of uninsured will increase by more than 50,000 to total 594,742 uninsured by 2010.

Young children up to age nine have made gains in insurance coverage over the last four years. Presumably, children have increasingly been enrolled in the public-funded programs such as Medicaid and Healthy Kids. However, the decrease in uninsured children up to age nine is surpassed by the increase in the 19-54 year old group resulting in a net increase of 2.1 percent for the entire Miami-Dade County population (from the 1999 survey to the 2003 survey).

| Table 1. Miami-Dade County Estimated Number of Uninsured 2003 - 2010 | | |
|---|---|---|
| Year | Under 65 Projected | Uninsured Projected |
| 2003 | 2,035,217 | 543,403 |
| 2004 | 2,062,686 | 550,737 |
| 2005 | 2,090,154 | 558,071 |
| 2006 | 2,117,623 | 565,405 |
| 2007 | 2,145,092 | 572,740 |
| 2008 | 2,172,561 | 580,074 |
| 2009 | 2,200,030 | 587,408 |
| 2010 | 2,227,499 | 594,742 |
| Note: Projected number of uninsured under 65 at 26.7% rate of uninsured, assuming the rate remains unchanged. | | |

Another significant finding from the current survey is the tremendous disparity in the uninsured between those who were born in the United States (15.6%) compared with those who were born outside the United States (47.1%). With more than one-half of Miami-Dade residents foreign born, this finding has significant political and practical implications.

The current uninsured rate of 26.7 percent is well above the national average of between 16 and 17 percent, and exceeds the state of Florida's 21.1 percent. Within Florida itself, only the rural mid-state counties taken together have a higher rate of uninsured.

B. Characteristics of the Uninsured

Being uninsured is not randomly distributed across the population, and being uninsured has consequences for health care and access to care. The problem is particularly acute among ethnic minorities, where the lack of health insurance is disproportionately high. Uninsured rates are highest among Hispanics, at 29.7 percent, followed by blacks at 25.3 percent. Race and ethnic differences are evident in the ranks of the uninsured. Just over half (52%) of the uninsured are female.[2]

People with lower incomes are also less likely to have health insurance. Eighty-three percent of the uninsured have incomes less than 150 percent of the Federal Poverty Level (FPL) ($26,940 for a family of four in 2002). In contrast, less than 24 percent of those with incomes between 200 and 250 percent of the FPL lack health insurance, and less than 12 percent of those with family incomes over 250 percent of the FPL are uninsured. The most frequently cited reason for not having health insurance is that it is too expensive and that

[2] This paper draws from the Miami-Dade County Health Policy Authority – Indigent Health Care Delivery System – Five-Year Plan report, September 2003. This report was coordinated by the Miami-Dade County Health Policy Authority and Williams, Stern & Associates.

premiums are too high. The more income one has, the greater likelihood of being insured. The uninsured are distributed unevenly across Miami-Dade County. High proportions of the uninsured are concentrated in the Miami urban center and in the county's more rural south, which are areas marked by extreme poverty and isolation. The rate is nearly 40 percent in the central part of the county, and as high as 43 percent in the Goulds/Perrine area of south Miami-Dade. However, most of the hospitals are located in the urban center of the county. Thus, poor or uninsured people living outside the urban center often must travel when they seek hospital care.

Compared to the insured, the uninsured are less likely to seek care, including prenatal and preventive care, as well as treatment for chronic conditions. Less than two-thirds (63%) of Floridians without insurance have a usual source of health care compared with 89 percent of those with insurance. Furthermore, 14 percent of the uninsured report the emergency room as their usual source of care, contrasted with only 3 percent of the insured. Finally, the uninsured are more likely to have delayed or not obtained needed medical care in the previous year (39% compared with 9%).

Although some non-citizens can afford to pay for their care, many more are undocumented, are indigent or nearly so, and lack any kind of insurance. Non-citizens, particularly the indigent, are more likely than others to enter hospitals through emergency rooms, indicating that this portion of the population is likely to do without care until a situation becomes urgent, at which point they go to the emergency room (ER). Seventy percent of hospital patients who are not citizens are admitted to hospitals through the ER compared to 51 percent of all patients.

C. Types of Health Insurance Coverage

Of the county residents under age 65 who have health insurance, two-thirds participate in employer-based insurance and 17 percent are on Medicaid or other government programs. Another 15 percent purchase their own insurance. Of those with private insurance, many have little or no prescription drug coverage or preventive health care, though they are covered for the costs of acute (episodic) illness.

D. Safety Net Providers

Publicly funded primary care clinics such as those of the Public Health Trust's Jackson Health System (JHS) and the Federally Qualified Health Centers (FQHCs) provide the major safety net services to indigent and uninsured residents. In fact, approximately 60 percent of the patients served at these safety net provider clinics are either without health insurance or are underinsured and pay on a sliding fee scale based on their income. These individuals then must pay for their own care, even though they likely have insufficient funds or insurance to cover the entire bill. For whatever fees the patient is not able to cover, the clinics ultimately absorb the costs. This can be considered as charity care when it is free care provided by facilities to those without a source of payment and unable to pay for their own care.

E. Consequences of Not Meeting Healthcare and Insurance Needs

The high percent of uninsured in Miami-Dade County has many implications for emergency room (ER) use, and the rate of inappropriate use may be higher here than for the nation as

a whole. People may use the ER inappropriately because they lack a regular source of medical care. They may also wait too long before seeking care, and the condition becomes an emergency. This is a very expensive way to deliver primary medical care, as costly capital and staffing infrastructures are needed to address emergencies. Many of the ER admissions could be avoided with improved availability of and access to community-based primary care. Additionally, lack of insurance is undoubtedly a major factor in emergency room usage. It is commonly known that the poor and uninsured frequently use the emergency department as their source of primary care, since their access to private physicians is limited. Further, the indigent often fear going to other places for care, or they may simply lack the knowledge of where to go. Ultimately, the safety net providers and the tax payers incur the costs. Significant expansion of the safety net with financial support at the state and federal levels is not expected in the near future due to the current political climate and the economy.

## III. Problem Identification and Flex Plan and Non-Flex Plan Alternative Resolutions

A. The Working Uninsured

Contrary to common belief, a full 60 percent of the uninsured are working. As employers face higher insurance premiums and either pass on costs to employees or eliminate health insurance benefits altogether, greater numbers of workers will be negatively impacted. Small employers are less likely to have insured workers. As a tourist economy, Miami-Dade has many small employers who do not offer health insurance to their employees. Nearly 30 percent of the full-time employees of Miami-Dade County businesses with fewer than ten employees are uninsured, compared with 5.9 percent in businesses of 100 or more employees.

B. Implementing Alternative Health Insurance Plans

Encourage private health insurance industry to offer a 'lean health plan,' which would be privately funded and affordable to low-income earners. This would be an alternative to the Flex Plan which would only be able to serve a portion of the working uninsured. Private insurers could be engaged in dialogue about the possibility of a wholly private plan also aimed at the Flex Plan target group.

C. Maximizing Public Program Health Coverage:

Expanding outreach efforts to screen and enroll all who are eligible for publicly funded health programs, including Medicaid and Healthy Kids (KidCare). The anticipated Office of Countywide Healthcare Planning could coordinate such efforts to maximize community organizations' existing and future outreach efforts.

D. Public Education Efforts:

In tandem with conducting outreach efforts to enroll residents in publicly funded health programs, public education and awareness about existing health care services and programs could be pursued. The idea is to help link or navigate the consumer to the appropriate type of services needed. Additionally, the feasibility of using individual tax incentives to

purchase health insurance could be explored as a way to increase the number of insured residents.

E. Flex Plan as a Working Uninsured Option

Of the county's 543,403 uninsured individuals, it is estimated that approximately 312,000 employed and uninsured individuals and their family members with incomes under 200% of the federal poverty level (FPL) would be eligible for health care coverage under the new state-sponsored program, i.e., the Health Flex Plan. The Health Flex Plan represents the state's effort to provide affordable health care insurance to the uninsured. The Flex Plan emphasizes basic and preventive care without the mandates under existing benefit programs. Catastrophic and high cost coverage is excluded from the Flex Plan in order to ensure financial viability of the program.

The desired outcomes of implementing the Flex Plan would be:

- Increased number of small business employers offering coverage for staff
- Reduced number of employed, low income workers without coverage
- Healthier workforce; fewer hours lost due to illness
- Reduced level of avoidable ER use

## IV. Critical Analysis of the Flex Plan

One argument in favor of Flex Plan is that it provides a bigger bang for the buck by leveraging federal dollars. This allows County dollars to go farther in providing health care. The Flex Plan premium attributed to the County would be 41% of the government's one third share with the federal government contributing 59% of the balance of the governmental share. The remaining two-thirds would be split evenly between employers and employees. Many programs are not able to provide these matching funds, for example, the TrustCare program is 100% funded by the county via the Public Health Trust. Patients do not pay any premiums or co-pays, there is no buy-in from employers, nor is there any federal matching funds.

Conversely, the Flex Plan is a new and different approach to a difficult local and national problem. It advances a unique way of financing the federal match using UPL dollars. Miami-Dade would be a national model for this type of funding mechanism and for the partnership this funding would bring with the County, State and private hospitals. As such there is much fine-tuning and decision making that must be made about the intricate details of the process. Additionally, one of the keys to success rests with the small business community. It is our understanding that the business community has expressed support and interest in the Flex Plan via the local chambers and the Greater Miami Chamber. It is important, however, especially given the failure of the Community Health Purchasing Alliance (CHPA's) that plans be implemented, possibly by the proposed Office of Countywide Healthcare Planning, which focus on the willingness to participate of the intended business community. The business community's participation will also be assessed by a survey that has been developed

by the Health Council of South Florida. It is clear that to correctly gauge the appropriate level of small business participation will require some further research.

## V. Health Flex and Similar Models Locally and Nationally

President George W. Bush is considering the proposal of an initiative that would allow small businesses to collectively purchase health insurance through a national trade association or professional society. This would allow small businesses to pool their buying power and negotiate lower premiums.

The Florida Agency for Health Care Administration (AHCA) has approved Flex Plan applications from American Care, Inc. and from Preferred Medical Plan. Both of these private organizations provide health insurance coverage in Miami-Dade County. American Care is a physician group, while Preferred Medical Plan is a licensed HMO provider. Both of these organizations offer individual plans for enrollees who purchase health care coverage directly from the sponsoring plan organization. These Flex Plans differ from the one proposed in this document in that they provide coverage to individuals, as opposed to groups. The proposed Miami-Dade County-sponsored Flex Plan is a group plan, to be purchased through a small business purchasing arrangement sponsored by a local government. The individual plans would thus not compete with the proposed Miami-Dade County sponsored Flex Plan, which would address the needs of the working uninsured through employer participation.

All Florida Flex Plans have the same requirements for offering services, and are subject to quality of care review by AHCA and monitoring for fiscal soundness by the Florida Department of Financial Services. The County will need to issue an RFP to secure the services of one or more licensed health plans, thereby ensuring the network can meet the needs of the community.

The Flex Plan targets businesses that primarily employ low-income workers who do not have access to health insurance. Employers must have fewer than 50 employees, must not have offered health insurance coverage within the past year, and have at least 75% of their employees who earn an average of $10 an hour or less.

The City of Jacksonville, Florida is expected to apply to operate a Flex Plan during September 2003. The JaxCare program conducted a one year "pre-pilot" test phase to develop the necessary provider networks in serving 50 enrollees. Upon Flex Plan application approval, JaxCare will be offered to Duval County employers who will pay 100 percent of the monthly premiums, estimated to be $50 per member per month. Eligible employees will pay patient co-pays for using services. Hospitals will donate a set cap on inpatient and outpatient services. Physicians will be encouraged to provide uncompensated care. The City of Jacksonville has agreed to fund the JaxCare $900,000 for the first year for non-hospital services and $1.6 million in the second year. Administrative services will be paid through grants and corporate donations. JaxCare represents a two-year public-private partnership which will serve 1,500 members. After the two-year program, officials will examine drawing down federal funds to provide a stable funding source.

Nationally, there are other programs that resemble a Flex-type program. Two suitable comparisons on developing and administering innovative health insurance programs are represented by the New York State (NYS) Department of Insurance's Healthy NY program and HealthPass in the City of New York. Both offer health insurance benefits for the working uninsured. Miami-Dade County, like New York City, has a high rate and number of uninsured individuals.

Healthy NY is an insurance program for the working uninsured and is administered by the NYS Department of Insurance. Employed individuals must qualify for the program based on income. Qualifiers must be at or below 250% of the federal poverty level and must be ineligible for Medicaid. Program participants pay a premium for health insurance coverage. In comparison, the proposed Miami-Dade Flex Plan would allow working uninsured individuals up to 200% of the poverty level, which is slightly less expansive. New York City Mayor's Office of Health Insurance Access conducts eligibility screening for public-funded programs, as is proposed for the Flex Plan.

The NYS Department of Insurance has HMO oversight. Under state law, the HMOs are required to participate in Healthy NY. The department has authority over contract forms, premium rates and administration of stop loss funds (the latter insulates the HMOs from some risk). The result is lower cost for small employers and employees. The State's charity care pool absorbs the risk. The HMOs conduct the eligibility process, while the State regulates and monitors the program. In the proposed Miami-Dade Flex Plan scenario, HMOs would compete via Request For Proposals to provide services to the working uninsured. It is anticipated that the Office of Countywide Healthcare Planning (Office), would administer the program and provide programmatic and fiscal monitoring. It is undecided whether the Office or the selected health plan(s) would perform outreach and eligibility determination. Also, a Third Party Administrator may prove to be cost effective in reviewing and processing bills and payments.

An interesting three-share model (premiums split between employer, employee and government) is Access Health, located in western Michigan, which started in September 1999. It is a community-wide coverage initiative developed by the Muskegon Community Health Project. Access Health offers small to mid-size businesses affordable coverage to provide healthcare benefits to employees and their dependents.

This community's population is 170,000 with an 11% uninsured rate and the target population is 3,000 working uninsured individuals. To date, there are more than 400 businesses enrolled, which represents 40% of the uninsured small business market. Business must have a median wage of $11.50 per hour and cannot have offered health benefits in the past 12 months. There are 1,500 individuals currently enrolled and by the end of this year, Access Health anticipates serving more than 1,700 individuals.

A $2.0 million annual budget is financed with a three-way premium split: 30% by the employer, 30% by the employee and 40% by a community match. The individual premium costs are $148 per member/per month (split $46 p/mo by the employer and the employee and $56 p/mo by the community). The community match is comprised of federal Disproportionate Share Hospital (DSH) funding.

Services are offered to the working uninsured (full time and part time) who have income levels that are just above the eligibility guidelines for Medicaid and State Children's Health Insurance Plan. They utilize Third Party Administrators for their claims related processing and for pharmacy services. Access Health, not the fee-for-service providers or employer/employees, assumes the insurance risk.

Another three-share model is Wayne County, Michigan's creation of the Health Choice program which splits the monthly premium one-third among employer, employee, and Health Choice. The contribution from Health Choice is from a hospital indigent care pool financed by the state Medicaid, federal Medicaid matching funds, and county general revenue. Eligibility is open to Wayne County businesses with three or more workers with an average wage of $10 or less and to businesses that have not offered insurance in the past 12 months. As of November 2002, the program had 14,646 members.

## VI. Flex Plan – Fiscal Impact and Potential Funding Scenarios

A. Premium Costs

Participants will pay a monthly premium with copayments for some services. The proposed benefits are estimated to cost $107 per member per month (PMPM) with an additional $13 PMPM for administration costs, for a total cost of $120 PMPM split three ways for a $40 cost to the employee, $40 cost to the employer, and $40 cost to the program.

The costs for an extensive outreach program are not included in this estimate and would likely add another $5 to $10 to the per member per month cost. The exact costs for this program will need to be determined by an actuary following completion of the final program design. The proposed program design requires participants to utilize physicians, hospitals and other providers who are part of the program network. Use of out-of-network providers (if included in the design) would require increased co-payments. The addition of mental health and substance abuse benefits would increase the per member per month cost by about $4.00 PMPM.

The actual costs may vary depending on the final design of the program. For example, the addition of more services, or changes in co-pays will change the overall cost of this program.

B. Governmental Share of Premium

The County could use local funds and combine these funds with money from the Federal government to cover the 1/3 County portion. The County's contribution of 41% of every dollar would yield 59% of every dollar from the Federal government. It is anticipated that start-up funding of approximately $500,000 will be required. The total program costs do not include the start-up funding. Estimated costs and funding are displayed in the tables below.

*FINANCING OPTIONS 20,000 CASELOAD MODEL*

| | | | | | | |
|---|---|---|---|---|---|---|
| | $7,797,600 | $2,599,200 | $2,599,200 | $1,065,672 | $1,533,528 | $2,599,200 |
| | $23,964,105 | $7,988,035 | $7,988,035 | $3,275,094 | $4,712,941 | $7,988,035 |
| | $33,580,000 | $11,193,333 | $11,193,333 | $4,589,267 | $6,604,067 | $11,193,333 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | $19,497,600 | $6,499,200 | $6,499,200 | $2,664,672 | $3,834,528 | $6,499,200 |
| | $59,923,480 | $19,974,493 | $19,974,493 | $8,189,542 | $11,784,951 | $19,974,493 |
| | $83,950,000 | $27,983,333 | $27,983,333 | $11,473,167 | $16,510,167 | $27,983,333 |

Federal funds will be leveraged for this program to the maximum extent possible via the utilization of Upper Payment Limit (UPL) financing arrangements to pull down federal funds to match local funds allocated to the program. Medicaid participating hospitals have the ability to access additional state and federal funds (i.e., funds in excess of the customary Medicaid payment) using the UPL methodology. The UPL is the maximum rate that can be paid under the Medicaid program. Florida has in excess of $100 million available in the private hospital UPL program, a portion of which could be allocated to Miami-Dade County.

C. Justification for County Investment

One argument in favor of the County participating in the Flex Plan is that it provides a "bigger bang for the buck" by leveraging federal dollars. This allows our County dollars to go farther in providing health care. For example, the TrustCare program, which is the Public Health Trust's pilot health benefit program in south Miami-Dade, is 100% funded by the County via the Trust. Patients do not pay any premiums nor co-pays, nor do employers pay, nor are there any federal matching funds. In contrast, under the Flex Plan, the County's portion would be 41% of the government's share of 33% (employer and employee each pay 33%). On a projected monthly premium of $120 per member, the County's share would be $16.40, not the full $120 nor the one-third amount of $40 that the employer and employee would pay. In essence, the County's contribution becomes 13.53% instead of 33%. This maximizes the funding and allows more residents to participate.

Additionally, the County should invest the funding initially in the Health Flex Plan because

of the long-term savings that can be reached through this innovative plan. In-depth preventive health care studies have shown that not only is the cost in emergency and indigent care rapidly rising, but the number of uninsured is reaching a vast epidemic. Investing in preventive health care will yield cost savings in future years.

It is inherent in the County's mission to build a healthier community. A healthier person results in a more productive and attentive worker and in return, this rewards our government's efforts with added value to our local community's productivity, profitability and efficiency.

D. Federal Funding

It is our understanding from AHCA that federal private hospital Upper Payment Limit (UPL) funds are available to draw down to be used with local County matching funds. The public hospital UPL funds are already capped as they are at the maximum allowable amount. However, there are sufficient funds from the private hospital UPL to draw down. In order to use a portion of the $100+ million in funding, one or more private hospitals need to agree to participate in the program. The South Florida Hospital and Healthcare Association passed a resolution supporting the recommendations of the Mayor's Healthcare Access Task Force, which include participation in the Flex Plan.

The process to draw down the federal UPL funds would require the County to allocate its contribution to the state (via AHCA) to be used as the match for the federal UPL funds. AHCA would disperse the combined government funds to the participating private hospitals who would then disburse the funds to the County for distribution to the health plan operating the Flex Plan. It is crucial that the County allocates its portion in order to draw down the federal funds.

E. Enrollment of 20,000 versus 50,000

The needs of Miami-Dade County's uninsured is great, and so should be our response to meet that need. Both the 20,000 and the 50,000 scenarios should entail a slow and careful phase in before the maximum caseload number is reached. In the 20,000 enrollee example, less than 10,000 persons would be insured at 12 months, while almost 25,000 persons would be insured under the 50,000 scenario. With the current economic situation forcing more and more workers into the ranks of the uninsured, it is incumbent upon the County to respond in a meaningful manner. After three years under the 50,000 caseload scenario, 9 percent of the projected uninsured population in Miami-Dade would be served (558,071 in 2005). In contrast, in three years, less than 4 percent would be served using the 20,000 caseload. It is recommended, however, that in order to temper the desire to quickly address the needs of the uninsured with the need to fine tune these innovative plans, the program should be scaled up slowly possibly over a five-year period. Individuals seeking care will be screened and if appropriate, first referred to public entitlement programs such as Medicaid or KidCare.

***20,000 ENROLLEES***

| | | | |
|---|---|---|---|
| | 5,415 | $1,440 | $7,797,600 |
| | 15,411 | $1,555 | $23,964,105 |
| | 20,000 | $1,679 | $33,580,000 |

*Assumes an 8% increase in cost per year.

***50,000 ENROLLEES***

| | | | |
|---|---|---|---|
| | 13,540 | $1,440 | $19,497,600 |
| | 38,536 | $1,555 | $59,923,480 |
| | 50,000 | $1,679 | $83,950,000 |

* Assumes an 8% increase in cost per year.

## VII. Long Range Issues

A. Sunset of Legislation

It is expected that more than three years of Miami-Dade County Flex Plan implementation would occur prior to the scheduled legislation sunset on July1, 2008. This period of time allows for ample opportunity to monitor programmatic and fiscal effectiveness to demonstrate to legislators the program's success. Legislators would be lobbied to either extend the sunset or make the legislation permanent. It is anticipated that AHCA would also assist in lobbying for the extension of this effort given that they are charged with its success.

As stated earlier, providing health care to the uninsured is a federal and a local problem. The uninsured is a complex issue that cannot be solved with a "one size fits all" program. Given Miami-Dade County's diverse population, several different strategies will have to be developed to address the needs of the working uninsured, undocumented aliens, children, and other affected populations. A host of federal and state agencies and organizations are already working on identifying solutions to this challenge. Enactment of the Flex Plan is just one, albeit important step towards developing a comprehensive solution to the health insurance crisis facing our community.

B. Addressing Long Term Needs

As proposed in pending County ordinance (September 9, 2003 agenda item 6A), the Office of Countywide Healthcare Planning (Office) would have the responsibility to administer any health care plans for the uninsured and programs for the County to maximize federal reimbursements or matching funds. As appropriate, the Office would work with the County Manager's Office, the County Commission, and the Mayor's Office to promote lobbying efforts on behalf of any state and federal legislation necessary to ensure the continued success and viability of the Flex Plan program.

It is, however, the responsibility of all County stakeholders to address the healthcare issue of the uninsured. All the partners in the County's health care system need to be part of the solution. The problem is too big for just one entity to be charged with the responsibility. There needs to be a true collaborative effort by all the health care stakeholders in the County to seek alternatives to lowering the rate of our uninsured and building a healthier community.

## Conclusion

As the local government policy-maker, the Miami-Dade County Board of County Commissioners is facing the need to provide more indigent health care locally, especially as the number of uninsured continues to rise.

This concept paper provided a detailed overview of the Health Flex Plan. It began by discussing the Mayor's Healthcare Access Task Force which resulted in the Miami-Dade Health Flex Plan Proposal. The key assumptions, anticipated enrollment and proposed benefit offerings were provided. An in depth analysis was done of Miami-Dade's uninsured population and the consequences of not addressing their needs. Alternatives to the Flex Plan including local and national models are discussed. The Flex Plan was critically analyzed and fiscal impacts with potential funding scenarios were presented in detail. Finally long range issues related to sunsetting of the legislation and addressing long term need were discussed.

Attachment D

greater miami chamber of commerce

# RESOLUTION

WHEREAS, the Greater Miami Chamber of Commerce is a organization of business and professions dedicated to economic progress and quality of life in Miami Dade County; and

WHEREAS, more than half a million residents in Miami Dade County do not have access to quality, convenient or affordable healthcare coverage and it is estimated that approximately 200,000 of these residents are working, uninsured individuals with incomes under 200% of the Federal Poverty Level (FPL); and

WHEREAS, Miami-Dade County is a community comprised largely of small businesses which can ill-afford costly health insurance benefits for their employees; and

WHEREAS, the Mayor's Healthcare Access Task Force recommended the creation of a pilot public/private partnership program, Health Flex Plan, to offer affordable health insurance to employed, low-income uninsured individuals; and

WHEREAS, program eligibility would focus on small businesses and place necessary emphasis on preventative primary care; and

WHEREAS, the cost would be split evenly three ways between the employee, employer and government;

THEREFORE BE IT RESOLVED that the Greater Miami Chamber of Commerce endorses the concept of the Miami Dade County Health Flex Plan and will work with Miami Dade County in promoting this important County initiative.

Peter W. Roulhac
Chairman

Isilio Arriaga
President/CEO

Approved this 17th day of November, 2003

GREATER MIAMI CHAMBER OF COMMERCE
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Statewide Toll Free (888) 660-5965
www.greatermiami.com

Attachment E

# South • Florida • Hospital • & • Healthcare • Association

## RESOLUTION

WHEREAS, the South Florida Hospital and Healthcare Association is a trade association representing hospitals, health centers, long term care providers, educational institutions, managed care companies, medical transportation companies and a variety of other organizations committed to improving the community's healthcare delivery system, and

WHEREAS, the South Florida Hospital and Healthcare Association has been representing its members' interests before elected officials, the public and key healthcare decision-makers since 1945, and

WHEREAS, the South Florida Hospital and Healthcare Association has long-established policies that seek to strengthen the healthcare delivery system by maximizing all available resources, including facilities, funding and personnel, and

WHEREAS, the South Florida Hospital and Healthcare Association strongly supports accountability and transparency in the governance of public funding for healthcare services, and

WHEREAS, the South Florida Hospital and Healthcare Association believes there is an inherent conflict of interest if the same entity that oversees local healthcare funding policies is also receiving the majority of those dollars, and

WHEREAS, the South Florida Hospital and Healthcare Association believes that public funding for healthcare services should "follow the patient" so that he or she can access appropriate care in his or her own community and all providers of services receive fair and equitable reimbursement, and

WHEREAS, the South Florida Hospital and Healthcare Association strongly opposes un-funded mandates and unnecessary regulatory requirements that limit providers' ability to offer high quality and accessible healthcare, and

WHEREAS, the Mayor's Healthcare Access Task Force has presented a series of preliminary recommendations that are consistent with these Association policies and would decrease the number of uninsured residents of Miami-Dade County.

NOW THEREFORE BE IT RESOLVED that the South Florida Hospital and Healthcare Association supports the preliminary recommendations of the Mayor's Healthcare Access Task Force and urges the Miami-Dade County Commission to adopt the preliminary recommendations as presented and ensure that they are further defined and implemented in the spirit in which they were developed.

Approved this 20th day of March, 2003.

Phillip Robinson
Chairman

Linda Quick
President

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A bill to be entitled

An act relating to Health Flex Programs; amending s. 408.909, Florida Statutes; providing for the statewide establishment of health flex plans; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (3) of section 408.909, F.S., is amended to read:

(3) PILOT PROGRAM.--The agency and the office shall each approve or disapprove health flex plans that provide health care coverage for eligible participants ~~who reside in the three areas of the state that have the highest number of uninsured persons, as identified in the Florida Health Insurance Study conducted by the agency and in Indian River County~~. A health flex plan may limit or exclude benefits otherwise required by law for insurers offering coverage in this state, may cap the total amount of claims paid per year per enrollee, may limit the number of enrollees, or may take any combination of those actions.

(a) The agency shall develop guidelines for the review of applications for health flex plans and shall disapprove or withdraw approval of plans that do not meet or no longer meet minimum standards for quality of care and access to care.

(b) The office shall develop guidelines for the review of health flex plan applications and shall disapprove or shall withdraw approval of plans that:

1. Contain any ambiguous, inconsistent, or misleading provisions or any exceptions or conditions that deceptively



Coding: Words ~~stricken~~ are deletions; words underlined are additions.

affect or limit the benefits purported to be assumed in the general coverage provided by the health flex plan;

2. Provide benefits that are unreasonable in relation to the premium charged or contain provisions that are unfair or inequitable or contrary to the public policy of this state, that encourage misrepresentation, or that result in unfair discrimination in sales practices; or

3. Cannot demonstrate that the health flex plan is financially sound and that the applicant is able to underwrite or finance the health care coverage provided.

(c) The agency and the Financial Services Commission may adopt rules as needed to administer this section.

Section 2. This act shall take effect upon becoming a law.



Coding: Words ~~stricken~~ are deletions; words underlined are additions.